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Three types of depressive illness of childhood (masked depression, acute depressive illness, and chronic depressive illness) are described; contributing factors (heredity and parental behavior) are discussed; and indications of depression are considered. Briefly reviewed are various methods of treating depressed children, including the use of antidepressive drugs. (SBH)

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NATIONAL INSTITUTE OF MENTAL HEALTH

CAUSES, DETECTION, AND TREATMENT OF CHILDHOOD DEPRESSION

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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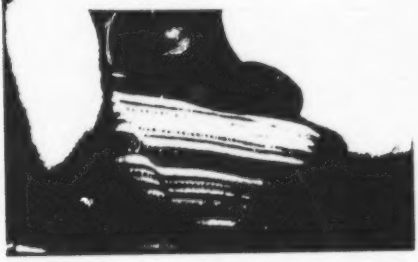

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Causes, Detection, and Treatment of Childhood Depression

by Herbert Yahraes

"I am the biggest troublemaker in my family," said a worried-looking 10-year-old girl. "I cry a lot and feel weird a lot."

Between spells of crying, a 12-year-old boy said, "I think I am the stupidist kid in class. . . . I never really try to kill myself, but sometimes I think to drown myself."

A dejected 8-year-old girl declared: "I feel ugly and like a dumbbell. . . . Sometimes I would like to kill my friends or my own stomach or arm. . . . Friends make fun of me all the time."

These children were talking to child psychiatrists at the National Institute of Mental Health (NIMH). Although none of these children was psychotic, all had high depression scores, as derived from two scales designed to measure depressive symptoms in children. The subjects were among the 30 children or grandchildren of 14 consecutive patients recently admitted to NIMH for observation and treatment of a depressive psychosis. The children were between the ages of 4 and 15.

Of the 30 child subjects, more than half were considered "overtly depressed" at the time of the interview.

A considerably lower rate of childhood depression had been reported in this same sample population by earlier investigators—perhaps, according to the NIMH team, because the earlier workers either did not get to know the children or else did not realize that the symptoms of childhood depression might be less marked than, or even different from, those of adult depression. At any one time, various studies indicate, as many as 20 children in 100 may be suffering from symptoms of depression. Though the incidence of this disorder used to increase steadily with age, as a recent report points out, "the growing rate of depression in the young has brought about a peak period in youth that outstrips middle age and is exceeded only by the elderly."

Masked Depression

Child psychiatrists Leon Cytryn and Donald H. McKnew, Jr., who were two leading members of the NIMH investigatory team, agree with Dr. William E. Bunney, Jr., Chief of the Adult Psychiatry Branch, NIMH, that many children diagnosed as hyperactive may actually be depressed. Certainly, they report, among children with *masked depression*, which is the commonest childhood type in these investigators' experiences, hyperactivity is common. This type of depression may also be masked by school problems, delinquency, and either behavior or psychosomatic disorders. Every once in a while, though, such children are likely to actually look or act depressed. The investigators arrived at their diagnosis when they discovered that many children who were not

obviously depressed nevertheless manifested in their dreams and fantasies the same depressive elements—such as frustration, despair, and hopelessness—as those shown by the clearly depressed children.

To gently remove the mask and get at the underlying trouble, these child psychiatrists, who work not only with the NIMH group but also at George Washington University Medical School and at Children's Hospital, Washington, D.C., use several measures. One is a psychiatric interview which notes any background of depressive signs—such as sadness, despair, feelings of hopelessness or helplessness, and thoughts of suicide. The investigators also evaluate what the child thinks of himself, that is, his self-esteem. And they elicit "fantasy material" by having the children make up stories, interpret pictures, and recount their dreams.

As an example of masked depression, these authorities tell about Albert, a 12-year-old boy, who had been sent to them because of his disruptive behavior in school. He was aggressive and hyperactive. His grades were poor and his social adjustment marginal. A look at the home situation suggested two major probable causes: The mother held a full-time job, was usually unavailable to her children, and had once been investigated for child abuse; the father was an alcoholic who assumed no responsibility for the family and who frequently beat Albert. In sum, the child, like many others with a similar condition, had experienced both rejection and depreciation.

Throughout the interview, Albert was apathetic and sad. "He described himself as dumb, as the laughingstock of his schoolmates, and expressed the belief that everyone was picking on him." He saw himself as inadequate and helpless. "On the fantasy level the boy showed a strong preoccupation with themes of annihilation, violence, explosions, and death, invariably with a bad outcome for the main figures. . . ."

Albert did not improve. In fact, 1½ years later he was sent to a residential school for delinquent boys.

The investigators suggest that the boy's delinquency and aggressiveness were attempts to escape from a basic depression. They admit that such a defense is self-destructive, but "it helps ward off the unbearable feeling of despair" and, on the basis of the newest evidence, seems to be far commoner than most of us think. In other words, many children who have a behavior problem may be basically depressed.

If a child is marked by hyperactivity, delinquency or other behavior disorders, school difficulties, or psychosomatic complaints, Cytryn and McKnew believe it would be a good idea to have him or her checked for depression.

The family members of the children with a masked depression, report these investigators, "often presented a picture of disorganization and severe psychopathology, usually in the form of a character defect, but gave no history of a clear-cut depressive illness."
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Acute Depressive Illness

In addition to masked depression, Cytryn and McKnew have found two other types of depression among children: *acute* and *chronic*.

In the *acute* type, there always seemed to be a clear cause, usually the loss of a beloved relative or someone else very close. Though the loved one had died in some cases, usually he or she—for any one of a variety of reasons, such as personal problems or a move—had simply reduced or cut off the love and care that the child had been counting upon and the loss of which was seen as rejection. In the case of 6-year-old Beatrice, the precipitating cause was traced to the rape of an older sister, 17, who had been serving as a mother substitute because the mother herself worked full time outside the home. "After the incident the sister became withdrawn, preoccupied, and less attentive," and within 3 months young Beatrice was admitted to a psychiatric ward because she had gradually withdrawn from activities, was failing in school, slept poorly, and lacked appetite. "Her mood," the psychiatrists report, "was markedly depressed, as evidenced by a sad and tearful facial expression, slowness of movement, monotone voice, and verbal expressions indicating hopelessness and despair."

After several days of hospital care and attention, but with no specific treatment for depression, Beatrice "became outgoing and started to eat and sleep regularly, her mood brightened, and she was sociable, active, and alert. . . ." Two years later the mother reported that the girl was still maintaining her gains.

Interestingly, Cytryn and McKnew report that such improvement, "despite the absence of any formal treatment program," has been "almost universal" in cases of acute childhood depression, such as Beatrice's. They suspect that it occurs because the child has been removed from one or more noxious environmental circumstances, "coupled with the rallying of the family around the child who is labelled ill because of the hospitalization." Many such children, whether or not they had availed themselves of followup psychotherapy, were found to have maintained their improvement, initiated during a brief hospital stay, even after 5 years.

Chronic Depressive Illness

Children afflicted with the third type of depression, *chronic*, report Cytryn and McKnew, differ from the others in these major respects: They have a chronically depressed parent, evidence that a genetic element is probably at play; they have been separated several times, from infancy on, from persons they had counted upon, evidence of an environmental force; and no single precipitating incident can be found.

Consider Caroline, who was referred to Cytryn and McKnew as an emergency case at the age of 7. She couldn't sleep, couldn't eat, and for several months had had screaming episodes. She had often threatened suicide because she was "a bad girl" and nobody loved her. Part of the problem was the girl's mother, a helpless woman overwhelmed by fam-

ily responsibilities, poor self-esteem, and a tendency toward frequent depressions. "Her only marriage was stormy;" Caroline's stepfather had beaten the child severely; then he and his wife had separated, but only for a while.

The trouble may have started many years before Caroline was born. For there is evidence that her mother, as a child, had been neglected by her own mother and been brought up in an atmosphere of violence. Evidence has been found that a condition which might be mildly described as "poor parenting" often is passed on from generation to generation, particularly in the case of child abuse. The abusing parent, investigators often have shown, is frequently the individual who was abused himself, or herself, as a child. Some children who were physically assaulted or otherwise maltreated as youngsters manage as adults nevertheless to become good parents; many others do not.

One of the most important persons in Caroline's life as an infant had been her paternal grandmother, but suddenly, when Caroline was 1 year old, her chief care had been shifted to a maternal aunt. The mother herself, when Caroline was 1½ years old and again when she was 4, had left her for several months.

After Caroline had been discharged from the hospital, she again "became depressed and developed abdominal cramps and diarrhea. When the mother again separated from the stepfather, these symptoms rapidly disappeared."

Two Forces: Heredity and Parental Behavior

In their observation of many children having at least one manic-depressive parent, Cytryn and McKnew found that more than 50 percent of the offspring were at least moderately depressed when interviewed—usually overtly so. Environmental forces were undoubtedly at work, because the shifting moods of the bipolar patient lead to "a sense of uncertainty and bewilderment on the part of the child."

Research by other investigators demonstrates that hereditary forces were probably heavily involved, too. Among the general population, the incidence of manic-depressive psychosis has been estimated at less than 1 percent; among close relatives of manic-depressives, it hovers around 10 percent. Further, studies of identical twins have shown that if one twin has this condition, the likelihood that the other twin also has it ranges from 50 to 100 percent. All of which is to say that the strength of the genetic element has been demonstrated but is not, usually, the whole story.

Obviously, in addition to heredity, the parent-child relationship is of prime importance.

Cytryn and McKnew found that many of their patients had "suffered rejection and depreciation by their parents or loved ones either all during their lives or at least over a period of many years." Such rejection may take many forms: blunt statements stressing the child's inadequacy; attitudes and actions that indicate a lack of respect or caring; a constant barrage of criticism and humiliation. Sometimes there was

no frank rejection or depreciation, just "a void in the parent-child relationship." The investigators say that the parents "may or may not be consciously aware of their behavior." They say, too, that "depreciation of the child can be shown through overprotection as well as through rejection; both attitudes convey the same basic message of the child's inadequacy and worthlessness." Conceivably, the child's depressive outlook is caused either "by identification with this negative view of himself" or "by a sense of alienation from important love objects," or by both.

Studies in Denmark strongly suggest that the relative importance of the two factors can be readily assessed. In children who are at risk to psychosis because they may have inherited a predisposition to it, the genetic factor is of primary importance, rather than the quality of the parent-child relationship. When there is no reason to suspect a genetic factor, however, the quality of the child's mental health seems to be strongly influenced by that of the parent-child relationship.

Detecting Childhood Depression Early

Indications of depression in children—particularly when something has gone wrong at home, playground, or school—are quite common, as Cytryn and McKnew point out. Usually, though, they do not last long. The problem is judged to be depressive illness when it continues for at least several months "and is associated with severe impairment of the child's scholastic and social adjustment and with disturbances" in eating and sleeping. "In more serious cases the child's thinking is affected by feelings of despair and hopelessness, general retardation, and, in the severe form, by suicidal thoughts."

In the best position to detect early indications of childhood depression, these investigators say, is the pediatrician or the family physician. Each knows the family's history and the parent-child relationship "and can observe the child directly for any sign of depressive mood and behavior." Also in a strategic position is the school or child guidance clinic.

The doctor's role may be particularly valuable in suspected cases of masked depression, "in which the child is usually regarded by the family [and often by the school] as delinquent or lazy." The doctor may try to investigate the case himself "through the use of simple playroom techniques which will elicit fantasy material in drawings, dreams, or selected projective tests or he may . . . refer the child to a psychiatrist. In either case, if the suspicion of a masked depressive reaction is confirmed, the all-too-frequent mishandling of such cases will have been avoided."

Any person evaluating or treating a depressed parent, Cytryn and McKnew advise, should "inquire about the emotional status of the patient's children. . . . Conversely, all child psychiatrists, when seeing depressed children, "should consider that a similar disorder may exist in the parents and siblings.

Treating Depressed Children

When the child is younger than 8 years old, and when the illness has not been very severe or of long duration, Cytryn and McKnew select parental counseling as "usually the treatment of choice." Through such counseling an attempt is made to change parental or other family practices, including depreciation of the child and preventable losses of loved adults, which are damaging to the child's feeling of self-worth. Otherwise these authorities advise family therapy, which includes the affected child, often coupled with individual psychotherapy for the young patient. Where the child has lost a major loved one, "the family needs help and guidance in providing adequate substitutes either from its own ranks or from outside resources. Where there have been frequent early losses, the family is encouraged to help compensate by increased involvement with the child."

These psychiatrists point out that many families, particularly those in which a child has a masked depression, "respond better to direct guidance and emotional support" than to the traditional interpretive and nondirective form of psychotherapy. "Of course," they add, "there are situations where traditional psychiatric intervention of any kind is not feasible. In such cases, the psychiatrist may have to collaborate with community resources such as juvenile court, halfway houses, foster homes, and even the police."

In adults, a wide variety of antidepressive drugs—including lithium carbonate, which is virtually a specific for treating manic-depressive, or bipolar, illness and then for preventing or markedly reducing the frequency and intensity of future attacks—have been proved efficacious. Bipolar illness is rare in children, so lithium is rarely used with them. The other antidepressives are being more widely used, but no comprehensive evaluation has been made of their effectiveness. However, in laboratory work with Rhesus monkey babies that had reached the stage of despair (retreating to a corner of the cage, ceasing to vocalize, and refusing food and water), antidepressant drugs have been shown to reverse the symptoms.

Another major question for research, in addition to the effectiveness of antidepressant medication in youngsters, is whether or not childhood depression leads, or predisposes, to adult depression.

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